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ABSTRACT

The need for a more responsive service system for people who are both mentally ill and homeless is a salient concern in America today. Preliminary research was conducted to examine how homeless mentally ill persons are processed by the currently organized network of human services in the nation's capital. Data were gathered in the summer of 1985 through semi-structured interviews of a purposive, stratified sample of 85 District of Columbia service providers, representing a wide range of human services, including psychiatric, medical welfare, rehabilitation, religion, law enforcement, and homeless shelters. Descriptive analyses of the data showed that referral pathways varied as a function of point of entry into the service network, severity of presenting symptoms (acute versus chronic mental illness), and whether there was a clear cut systemic focal point of responsibility for service provision. Differential referral patterns emerged in the handling of acute versus chronic mentally ill homeless persons. Nearly one-half of the referrals for chronics were inappropriate in contrast to one-fourth of those for acutes. The centrality of three systems to the service network for this population was observed: community mental health centers (CMHCs) and service programs, general hospitals, and shelters. Overall resource utilization patterns suggest overreliance on general hospitals as a panacea for the problems of homeless mentally ill persons, indiscriminate dumping on shelters, and underuse of CMHCs as a system of comprehensive care. (Author/NB)

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PATHWAYS FOR HOMELESS MENTALLY ILL PEOPLE IN WASHINGTON, D.C.

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Abstract

This preliminary research describes how homeless mentally ill persons are processed by the currently organized network of human services in the nation's capital. Data were gathered in the summer of 1985 through semi-structured interviews of a purposive, stratified sample of 85 District of Columbia service providers, representing a wide range of human services, including psychiatric, medical, welfare, rehabilitation, religion, law enforcement, and homeless shelters. Descriptive analyses of the data show that referral pathways varied as a function of point of entry into the service network, severity of presenting symptoms--acute versus chronic mental illness, and whether there was a clear cut systemic focal point of responsibility for service provision. Differential referral patterns emerged in the handling of acute versus chronic mentally ill homeless persons. Nearly half (47%) of the referrals for chronics were inappropriate in contrast to one-fourth of those for acutes. The centrality of three systems to the service network for this population was observed--community mental health centers and service programs, general hospitals, and shelters. Overall resource utilization patterns suggest overreliance on general hospitals as a panacea for the problems of homeless mentally ill persons, indiscriminate dumping on shelters, and underutilization of CMHCs as a system of comprehensive care.

Homeless Mentally Ill People
An Analysis of the Referral Network

The need for a more responsive service system for people who are both mentally ill and homeless is a salient concern in American communities today. Evidence that current service networks are inadequate is reflected in the high prevalence of mentally ill persons on the homeless rolls. Nationally, it is estimated that a minimum of 25 to 50 percent of any homeless group suffer from serious, chronic mental illness (Arce & Vergare, 1984). In the District of Columbia, the statistics are even more alarming. Among sheltered adults, estimates range from 57 percent (Lane & Depp, 1986) to as high as 74 percent if one combines chronic schizophrenics (39%) and chronic alcoholics and alcoholic-schizophrenics (35%) (Torrey, 1984). Applying DC's most definitive homeless census estimate of 6,453 (Robinson, 1985) to these figures suggest that there are possibly 3,678 to 4,840 homeless persons who suffer from major mental illness in the District of Columbia.

Despite the fact that seriously mentally ill persons constitute the largest single subgroup of the homeless population, few cities have an organized system of services to meet their unique needs. Typically, services for the homeless mentally ill group are fragmented and uncoordinated across agencies, having no clear focal point of responsibility. As a consequence, homeless mentally ill persons often

experience what Levine (1984) has coined "dual disenfranchisement from society and its agents of service delivery: the mentally ill are often excluded from programs designed to serve the homeless, and those who are homeless are typically screened out from receiving services designed for the chronically mentally ill" (p. 173).

In planning for this group most research studies have focused on characterizing the subject population in terms of prelavence rates, demographic characteristics, psychosocial attributes, and service needs (see reviews by Bachrach, 1984; Milburn & Watts, 1984). While these efforts are necessary to identify the population and their unique service needs, research is also needed to assess the characteristics and functioning of the service network relative to this group. Little has been done in this area.

Special acknowledgments are extended to Deborah Dantzler-Williams, co-principal investigator, and Norman Dockett, Jean Habteab, Mary Lewis, Robert Little, Donald Lockley, and Anna Reuben, who served as research assistants and interviewers.

This paper describes a preliminary study of how homeless mentally ill persons are processed by the currently organized network of human services in the District of Columbia. Funded jointly by the University of the District of Columbia Center for Applied Research and Urban Policy and the DC Department of Human Services, the study examined the flow of mentally ill homeless persons through the human services network. It sought to identify the typical pathways followed, critical decision points within the referral network, what happens to people at these points, what kinds of decisions are made, based on what kinds of information, and with what potential outcomes.

Specific questions explored in the study were whether the referral pathway for homeless mentally ill persons varies as a function of point of entry, severity of presenting symptoms, and resource availability.

Methodology

Sample

Data were gathered in the summer of 1985 through semi-structured interviews of 85 District of Columbia service providers, representing a range of service systems needed by the homeless mentally ill. Ten service systems were sampled, including:

1. mental hospital
2. general hospitals
3. health centers
4. community mental health centers and services programs (CMHC)
5. substance abuse
6. welfare
7. rehabilitation
8. criminal justice
9. religion
10. shelters and homeless food services

Housing was also included but later dropped when it became apparent that with the exception of DC public housing, most housing services were decentralized and integrated into programs in other sampled systems.

Within each of the 10 systems, a combination of purposive and stratified sampling was used in the selection of respondent organizations and then service providers within select units of those organizations. Sampling was restricted to government agencies in all systems except community mental health centers and service programs (CMHC), general hospitals, shelters, and religion. CMHCs included public and private community mental health centers and their contract-service programs. Service providers were selected based on

position held and stratified (where possible) by job level to include "line staff"--those in the most direct and frequent contact with clients, "midlevel managers"-- supervisors and directors of program units, and "administrators"--division, program, and center chiefs.

Data from 77 of the 85 service providers interviewed were usable in the analyses. Respondents represented a sophisticated group of service providers in terms of educational level and years experience with mentally ill and homeless individuals. There were 24% with doctorates, 47% masters, 19% baccalaureate, and 10% high school level. The mean number of years work experience with the mentally ill was 13.06 (SD = 8.83) and with the homeless was 9.44 (SD = 8.28). Surprisingly, more line staff had 8 or more years experience with the mentally ill (83%) and homeless (64%) than midlevel managers (48% and 44% respectively) and administrators (79% and 35% respectively). Line staff constituted 32% of the sample, midlevel managers 42%, and administrators 26%. Specialty areas of training included medicine (11%), psychology (10%), social work (37%), administration (10%), ministry (7%), and other (25%).

Procedure

A semi-structured interview schedule was designed to gather information on sources and types of incoming service referrals, services provided, outgoing referral dispositions, interagency coordination and linkages, perceived barriers and recommendations, and perception and use of specialized service programs for homeless persons. The interview elicited hypothetical referral decisions by asking service providers where they would refer a "severely emotionally disturbed homeless adult whose level of functioning is grossly impaired in areas of work, social relations, personal hygiene and use of leisure time," for 8 categories of services including basic needs (shelter, food, clothing, and bathing), psychiatric, medical, welfare entitlements, rehabilitation, housing, case management and followup services. Consent was first obtained from agency administrators and then from service providers to be interviewed.

Results

Several limitations of this exploratory research render the results tenative. First, the sample may not be representative. In some instances selection of respondents within the program and job level strata stipulated was made by program administrators. This may explain the high levels of training and experience represented among the line staff interviewed. With this bias operating, the observed results may reflect the "system's best case" performance potential. Second, due to variability in sample size across service systems, the overall pattern of referral decisions would be biased in favor of the systems with the largest sample size. Nonetheless, the data do provide preliminary descriptive information on referral and resource utilization patterns

as the basis for formulating hypotheses for more rigorous examination.

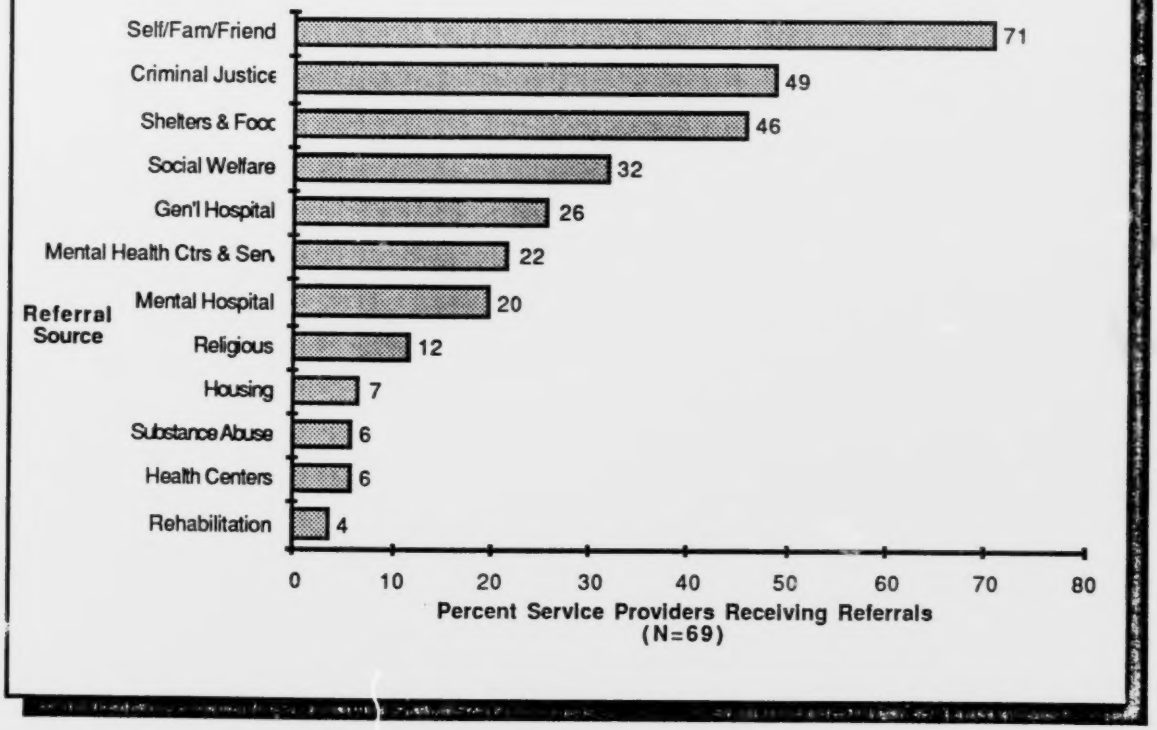
A systems perspective is used in conceptualizing and organizing this section which describes characteristics of the DC service network for homeless mentally ill persons. Major topics discussed include (1) sources of incoming referrals, (2) variability in referral decisions as a function of point of entry into the network and severity of presenting symptoms, and (3) general patterns of resource utilization.

Where People Go To Seek Help: Sources of Incoming Referrals

Figure 1 shows the percent of service providers receiving incoming referrals from each of 12 service systems. Based on the responses of 69 service providers to the question, "From what sources do your adult mentally ill homeless referrals come," it appears that the systems where initial entry occurs with the highest frequency include self/family/friends, criminal justice, and shelters. Systems entered with moderately high frequency include welfare agencies, general hospitals, community mental health centers and service programs, and mental hospitals. The least frequent initial entry occurs in systems of religion, housing, substance abuse, neighborhood health centers and rehabilitation. Further substantiating this ordering of entry points, the number of times a system was ranked by service providers as the "number one" most frequent source of incoming referrals is also shown in Table 1. The rankings follow the same order with the exception of the housing system which was never ranked as the most frequent.

The relatively small percentage of service providers receiving referrals from systems of religion, housing, substance abuse, health centers, and rehabilitation, may suggest several things. First, it is plausible that a system may be known to have limited resources to solve problems of homeless mentally ill individuals and therefore not be approached. A case in point is DC public housing where there is a ten year waiting list. Second, a system may have restrictive criteria for entry, serve a select population, and have limited interface with other components of the service network. For example, the DC Rehabilitation Administration's Work Incentive Program only serves referrals from the AFDC Program; its SSDI program requires a DC address as criterion for embarking on the lengthly, complicated application procedure which homeless mentally ill persons are rarely able to negotiate; and, one DC goverment alcoholism program serves persons with a primary diagnosis of alcoholism only, excluding alcoholics with a primary diagnosis of mental illness. Third, a system by virtue of the services it provides may represent a secondary or tertiary level of entry for service provision, such as the WIN program mentioned above which receives referrals only after a person has entered the AFDC program. Lastly, of course, it is also possible that low entry rate is an indicator of bureaucratic inflexibility and insensitivity to the specialized needs of the homeless mentally ill.

Figure 1. **Sources of Incoming Homeless Mentally Ill Referrals**



Pathways for Homeless Mentally ILL Persons, by Dr. K.H. Dockett, University of the District of Columbia, Center for Applied Research

Table 1

Magnitude of Incoming Referrals By Source

Source	No. Times Ranked As Most Frequent Source
Self/Family/Friends	37
Criminal Justice	17
Shelters	16
Social Welfare	8
General Hospitals	7
Mental Health Ctrs & Services	6
Mental Hospital	6
Religious	3
Housing	0
Substance Abuse	2
Health Clinics	1
Rehabilitation	1

Point of Entry into the Network

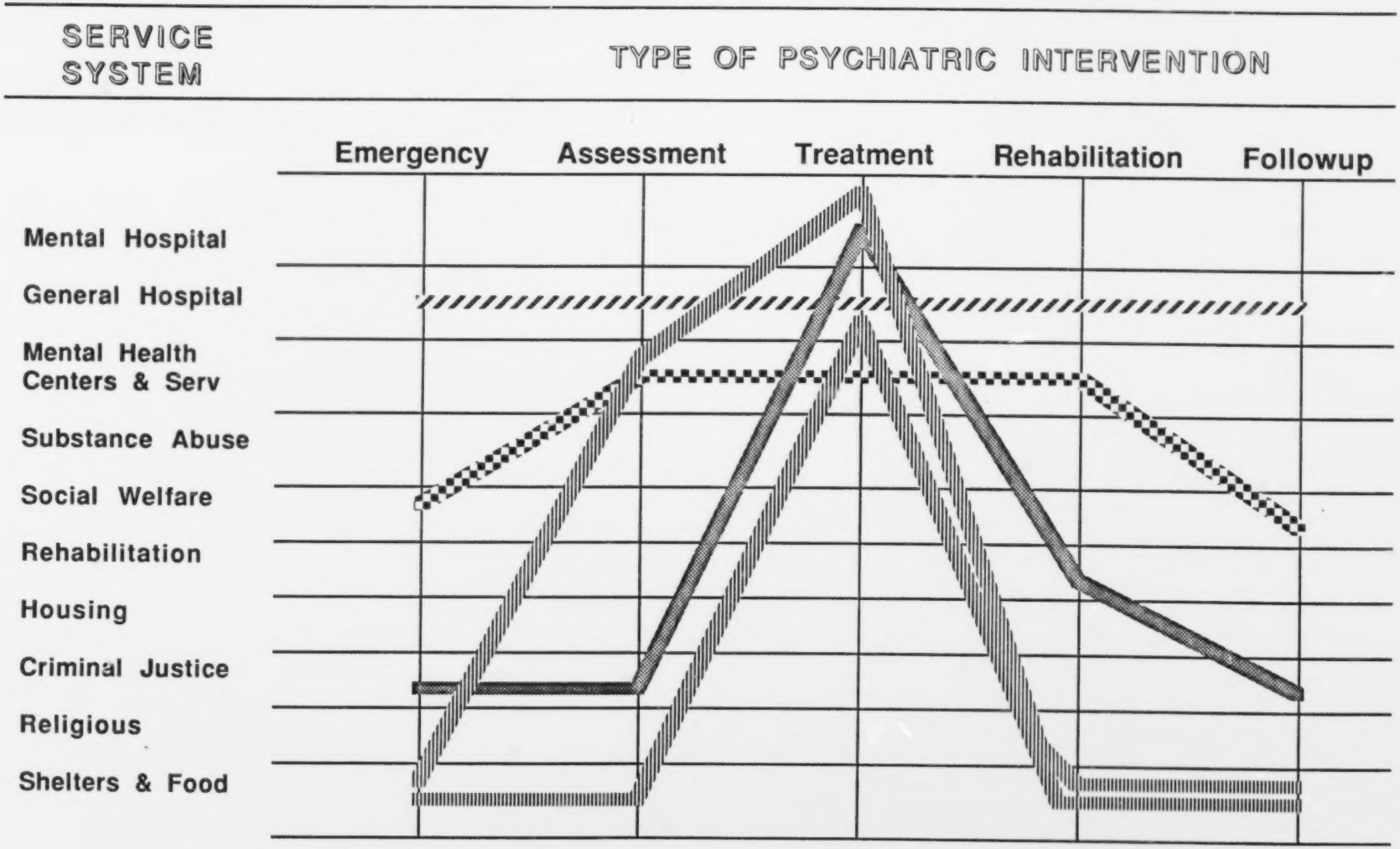
One hypothesis of the study was that the referral pathway for homeless mentally ill persons would vary as a function of point of entry--the system in which help is initially sought. To test this hypothesis, service providers were asked to assume that a homeless mentally ill adult had come initially to their organization for emergency help, and to indicate, for each of 22 services needed, whether their organization provides the service, if not, where they typically refer the person, and if that source is unavailable, what backup service they would use.

For purposes of illustration, a sample of the obtained results is presented in Figure 2. This figure depicts the referrals decisions made by four provider systems for four types of psychiatric services--assessment, in-patient treatment, social and mental health rehabilitation, and follow-up. The four systems selected were identified in the study as the most frequent sources of incoming referrals and therefore illustrate the most common pathways followed by homeless mentally ill people for psychiatric services.

The results show that if a homeless mentally ill person (HMIP) initially went to a general hospital with a psychiatric emergency, they typically would receive psychiatric assessment, in-patient treatment, and followup services within that system. For social and mental health rehabilitation the person would be served either in house (44%) or referred (56%) primarily to CMHC (14%), rehabilitation service programs (14%), and other (21%). If they initially entered the network through the public welfare system, they would be referred to CMHC for assessment, treatment, and rehabilitation, and would be followedup back in the welfare system. If entry was through the criminal justice system, they would be assessed in that system, referred to St. Elizabeths for inpatient treatment, to a non-CMHC system rehabilitation program for rehabilitative services, and returned to the court system for followup. If initial entry was through the shelters, two paths might be followed. One involved referrals to CMHC for assessment, to St. Elizabeths for inpatient care, and back "home" for rehabilitation and followup. The other path involved retention in the shelter system for all services except for inpatient care referrals to the general hospitals.

Thus, it appears that distinctly different referral pathways may be followed based on where one enters the service network. Assessment services were widely dispersed, provided in-house or through CMHC. Rehabilitation services, also widely dispersed, were sought in-house or from CMHC and non-CMHC rehabilitation programs. Differences in shelter referral routes may reflect the emergence of multiservice shelters versus the bare bones/basic needs type, both of which were included in the sample.

Figure 2. PATHWAYS FOR HOMELESS MENTALLY ILL PERSONS



Pathways for Homeless Mentally ILL Persons
by Dr. K.H. Dockett, Univ of the District of Columbia
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Severity of presenting symptoms:
The Handling of Acutes Versus Chronics

A second hypothesis was that the referral pathway would vary as a function of the severity of presenting symptoms. The specific concern underlying this hypothesis was whether service providers make any distinctions between homeless mentally ill persons who manifest symptoms of the acute versus chronic phase of mental illness. Accurate identification of these two types is critical in order to make appropriate referrals, since they have uniquely different service needs. To test this hypothesis, respondents were presented with two vinyettes which described an acute and a chronic mentally ill homeless adult as follows:

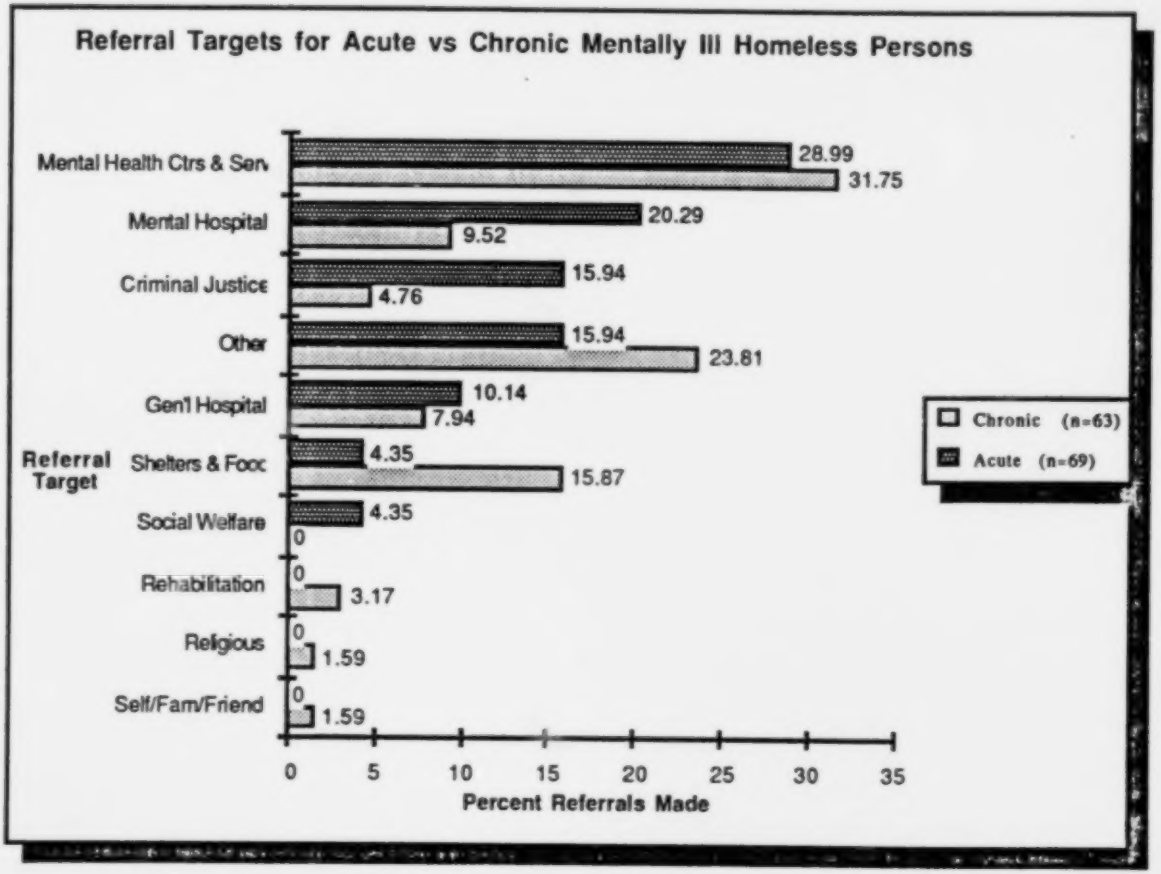
Vinyette 1 - Acute
Where would you refer a homeless mentally ill client whose behavior is disruptive, who hears voices, is silly, appears to be laughing at nothing, claims to be god, and whose speech is incoherent? This person may or may not have a history of in-patient psychiatric hospitalization.

Vinyette 2 - Chronic
Here's another hypothetical case: An odd acting, socially withdrawn person who doesn't react emotionally, whose thinking is very strange, and who generally does not appear to be disturbed by their homeless state.

Figure 3 presents the results in terms of the percentage of referrals made to various systems for the acute and chronic types. For the acutely ill person who requires immediate attention and hospitalization referrals to mental health-related agencies totaled 59% These included community mental health centers and services (29%), mental hospital (20%), and general hospitals (10%). These referral decisions, when added to the 16% to criminal justice for police intervention, constitute 75% of the choices made. Collectively, they may be viewed as appropriate since they are made to sources capable of providing or transporting the person to adequate treatment sources. The 25% combined referrals to shelters (4%), welfare systems (4%), health centers (1%), and other (17%), are questionable and require further examination.

For chronics, who pose no immediate danger but need ongoing structured involvement in psychiatric and rehabilitation programs for an indefinite period of time, the picture changes considerable. Referrals to traditional mental health-related agencies totaled 50%, including CMHC (32%), mental hospital (10%), and general hospitals (8%). Adding the 3% to rehabilitation, totals a minimum 53% referral rate that could be considered appropriate in contrast to a 75% appropriateness rate for handling the acutely ill. The remaining 47% combined referrals to criminal justice (5%), other (24%), shelters

Figure 3.



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(16%), religion (1.5%), and self, family, friends (1.5%) are of concern.

The overall pattern of referrals for chronics relative to the acutes shows:

1. decreased use of mental hospitals (-10%), general hospitals (-2%), and police intervention (-11%), totaling 23%.
2. increased use of CMHC (+3%), shelters (+12%), and other (+8%), totaling 33%.
3. additional use of more diverse systems, including rehabilitation (+3%), religion (+1.5%), and self, family, friends (+1.5%), totaling 6%.

In general, the referral pattern for acutes relies more heavily on CMHC, hospitals and criminal justice while that for chronics shows heaviest reliance on CMHC, shelters and other. While some of these differences reflect desireable patterns, concerns are reflected in the following. There appears to be less consensus and appropriateness in the handling of chronics where the appropriate referral rate was slightly over half in contrast to three-fourths for acutes. The startling increased use of shelters for chronics may reflect indiscriminate dumping by outside agencies. What's happening in referrals to "other"--16% for acute; 24% for chronic--needs further examination. Are there special resources available? Are these appropriate referrals? Or is this an artifact of the coding categories used?

Whether these overall patterns reflect the absence of a clearly identified service network for chronics, limited resources, or poor understanding of the chronic mentally ill person's needs requires additional study.

Patterns of Resource Utilization

Data were examined to determine the overall pattern of system resource utilization for multiple service needs. Table 2 shows the percentage distribution of referrals across 12 systems for each of eight categories of service needs.

For basic needs of shelter, food, bathing, and clothing, 50% of the referrals were to shelters, followed by hospitals (14%), welfare (9%), and religion (8%). All other systems were less than 8%.

For psychiatric needs including screening, assessment, inpatient, outpatient, and emergency, referrals were dispersed across traditional health-related systems. CMHC received 32% of the referrals, followed closely by general hospitals (28%), and then mental hospitals (15%). All others were less than 7%.

Table 2

System Resource Utilization:
% Distribution of Referrals To Provider Systems By Service Need Category

Provider System	Service Need Category							
	Basic Needs	Psychiatric	Medical	Entitlement	Rehabilitation	Housing	Case Mgmt	Follow Up
n	(214)	(285)	(241)	(207)	(112)	(54)	(47)	(45)
Mental Hosp	01(-)	15	03	-	02	02	02	04
Gen'l Hosp	14	28	69	06	11	04	11	13
Health Ctr	01(-)	07	08	01(-)	03	02	06	04
CMHC & Serv	04	32	04	01(-)	19	09	21	22
Sub. Abuse	01(-)	03	04	03	03	-	04	02
Welfare	09	01(-)	-	65	08	07	13	13
Rehabilitat.	01	02	04	06	35	-	09	07
Housing	-	-	-	-	-	48	-	-
Criminal Jus	-	02	-	-	-	-	06	02
Religious	08	-	01(-)	01(-)	05	06	02	02
Shelter	50	04	03	06	09	07	17	18
Other	07	01	08	10	06	13	09	07

- = total number of referrals summed across all service needs within a category

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For medical needs, including assessment, inpatient and outpatient, and emergency, general hospitals were uncontested with 69%. Neighborhood health centers appeared underutilized at 8% and all others were less than 7%.

For entitlement programs including stable income, emergency financial assistance, medical insurance, and food stamps, the DC government welfare programs were the clear focal point of referrals--65%. The other referrals were dispersed 6% each across rehabilitation programs, shelters, and, general hospitals, and the remainder were less than 4%. Interestingly, CMHC received less than 1% referrals in this category despite its mandate for comprehensiveness of programs and continuity of care. Also noteworthy was the low rate of referrals to SSDI (less than 1%.)--a program for which severely disturbed homeless persons are by definition eligible.

For rehabilitation needs including social, mental health, and vocational rehabilitation the greatest dispersion across systems was found. The highest referral rate was to various non-CMHC rehabilitation programs (35%), followed by 19% to CMHC, 11% to general hospitals, 9% to shelters, and 8% to welfare. All others were less than 6%. Again, examining the role of specific programs, public community mental health centers received only 5% of the rehabilitation referrals and the public rehabilitation program for the disabled and handicapped received only 6%. One wonders about the role of these public programs in serving the homeless mentally ill.

For housing needs, 48% of the referrals were to some type of housing program, followed by 9% to CMHC, and 7% each to shelters and welfare agencies. All others were less than 7%.

Referrals for case management and followup were widely dispersed with most systems providing their own services or out-referring to CMHC (22%) or shelter systems (18%).

Dispersion of services

Examining the overall dispersion pattern, we found that referrals for certain services were more widely spread across systems than others. The high dispersion service referrals (defined as referrals to at least 10 of 12 systems) were for social and mental health rehabilitation, psychiatric outpatient care, case management, and followup. Low dispersion services referrals (defined as referrals to less than 8 systems) were for shelter, food, psychiatric inpatient care, medical inpatient & outpatient care, and entitlement programs for stable income, food stamps, and medical insurance.

Low dispersion of referrals suggests the existence of a clearly identified focal point in the network for a service. For example, service providers know where to send people for shelter, medical

services, and entitlement programs. The converse may also be true. Referrals spread out across many different systems may suggest the absence of a clear focal point of responsibility and thus no organized network of service delivery. This appears to be the case for the highly dispersed services identified.

Diversity of systems

An interesting pattern emerged in terms of the range of services sought within a particular system--perhaps an indicator of the centrality of a system within the overall network of services for the homeless mentally ill. The widest range of services were sought from general hospitals, shelters, and CMHC. However, general hospitals were referred to more often for more services (22 out of 22), even more so than CMHC (20) and rehabilitation systems (18). This finding suggest that the general hospital may be looked upon as a panacea for the problems of homeless mentally ill people.

Moreover, shelters were referred to for nearly everything (21 out of 22 services), yet provide only a limited range of services. This pattern of indiscriminate referrals might plausibly be related to a number of factors acting singlely or in complex interaction. These include (a) rejecting attitudes toward servicing "filthy, infested homeless persons," (b) lack of knowledge regarding resources available, and (c) lack of resources, to name a few.

CMHC were most heavily relied on for psychiatric screening, assessment and outpatient care, social and mental health rehabilitation, case management and followup services. However its role relative to general hospital, shelter, and rehabilitation systems is ambiguous. For traditional psychiatric services its referral rate (31.5%) was only slightly more than general hospitals (28%). Similarly, for social and mental health rehabilitation it received about half as many referrals as non-CMHC rehabilitation programs (18.8% versus 34.8%) and less than 1% of the referrals for entitlement services. In fact, shelters received more entitlement referrals (6%). Thus, while CMHC did receive referrals for 20 of the 22 service needs indicating its centrality in the network, the magnitude of its referrals relative to general hospital, rehabilitation and shelter systems suggests a less than dominant role in servicing the homeless mentally ill population. Rather a pooling of multiple system resources appears to be indicated.

Discussion

All three hypotheses appear to be supported based on descriptive analyses. Referral decisions did vary as a function of entry point, severity of symptoms, and whether a focal point of responsibility existed for a particular service. We observed distinctly different

referral pathways for psychiatric services based on where one entered the network. Thus, a homeless mentally ill person's initial encounter with the human service network represents a critical decision point in the referral process. Point of entry determines who makes the decision about what kind of service shall be given, what kind of decision will be made, based upon what kind of information, and with what outcome. Consequently interventions aimed at improving the kinds of referral decisions made might well target the most frequent sources of incoming referrals. Self/family/friends, criminal justice, and shelters represent prime targets for preventive intervention to improve the handling of this group. Education and consultation strategies would seem appropriate here. Interventions for currently low entry systems that provide essential services, such as housing, rehabilitation, and SSDI, are obviously needed and should be given considerable attention.

As expected differential referral patterns emerged in the handling of acute vis-a-vis chronic mentally ill homeless persons. For acutes primary reliance was on systems of CMHC, general and mental hospitals, and police intervention while for the chronics, CMHC, shelters and other unidentified sources dominated the picture. While the decreased use of hospitals and criminal justice interventions for chronic mentally ill homeless people seems desireable, specific problems were seen the overall pattern of referrals for this group. There was less consensus and appropriateness in the handling of chronics. Nearly half the chronic referrals were inappropriate, including the sharp increase in referrals to shelters, which in most instances are not equipped to provide for the highly specialized needs of the chronically mentally ill. Further study is required to understand why this is happening as the basis for designing a suitable intervention.

In examining the overall pattern of system resource utilization for multiple service needs, three systems emerged as central units in the network for homeless mentally ill people--general hospitals, shelters, and CMHC. General hospitals appear to be used as a panacea for the problems of the homeless mentally ill. They received more referrals for more service needs than any other system including CMHC. As a traditional medical service, hospitals appear to be relied on too heavily to provide all services--many of which fall outside the medical paradigm.

Shelters seem to suffer from indiscriminate dumping by other systems for nearly all homeless mentally ill service needs. Although the emergence of multiservice rehabilitative shelters is on the rise, most do not possess the resources to adequately provide for this population. The consistent pattern in this study's findings of shelters being relied upon to provide comprehensive care raises several questions: Have shelters by default become the focal point of responsibility for the homeless mentally ill? Is the "dumping" pattern a result of inadequate resources, limited knowledge of existing

resources, negative attitudes toward working with this population, and/or a lack of structurally assigned systemic responsibility for serving people who are both homeless and mentally ill? Should shelters become alternative service settings or should traditional settings be changed to accommodate the specialized needs of homeless mentally ill persons? This mix of policy and empirical questions while very complex will need to be tackled as a step toward improving our ability to make a dent in this growing problem.

CMHC also emerged as a central system in the service network, although its role vis-a-vis the general hospital, shelter, and rehabilitation systems is unclear. With the exception of psychiatric outpatient care, it did not emerge as uniquely dominant in the provision of care for homeless mentally ill persons. Rather, responsibility for servicing the psychiatric and rehabilitative needs of the homeless mentally ill seemed to be shared primarily with the three mentioned systems. Moreover, the CMHC system appeared to be underutilized as a system of comprehensive care particularly in the provision of basic needs, medical, and entitlement services. Does this finding reflect erosion in the basic concepts of community mental health, i.e., accessibility, comprehensiveness of services and continuity of care? Are services such as medical care and entitlement programs no longer decentralized in CMHC? Have disincentives for outpatient care from third party reimbursement sources curtailed the role of CMHCs and created shifts in service utilization favoring general hospitals? Whether these findings reflect a general pattern of retrenchment in community mental health center service programs or problems in the provision of services for homeless mentally ill persons remains to be answered.

A final note. The role of the public rehabilitation service system in serving this population needs close examination. Referral patterns did not establish it as central to the network but rather suggest underutilization of SSDI and other services for the disabled. Of course, some of the public rehab programs were never intended for seriously mentally ill persons. Nonetheless, while many homeless mentally ill individuals may not be functioning at a level necessary to benefit from the more vocationally-oriented programs, their disability should quality for SSDI. However, access problems appear exascerbated by the very characteristics of homeless mentally ill persons that need intervention--the inability to engage in sustained complex contact with social institutions in order to be served. The question of concern is what role should public rehab programs serve for this population.

In summary, this study has attempted to describe key characteristics of the service network for homeless mentally ill people in the District of Columbia. It has identified the typical referral pathways used for multiple service needs, critical points in the network and other factors that influence the kinds of decisions made, how acute

versus chronic mentally ill homeless people are handled, and overall patterns of resource utilization. Like most descriptive research it has raised more questions than it has answered. The more difficult task of providing explanations, recommending and testing specific interventions is left, as it must be, to future research.

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